CULICCHIA
NEUROLOGICAL CLINIC
Complete Neuro-Care for the Gulf South

MEDICAL SECOND OPINION BRAIN TUMOR AND NEURO-ONCOLOGY REQUEST FORM

I am requesting Culicchia Neurological Clinic to provide a remote second opinion of my condition. Please check all that apply:

I have:

□ a brain tumor.

□ cancer that has spread to my brain and/or other parts of my nervous system

□ cancer with neurologic symptoms that may be due to the cancer or the treatment of my cancer

Please provide a short description of your history relating to this diagnosis and the question(s) to be answered by this second opinion:

_____

_____

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_____

I understand that this second opinion is based solely on the materials provided to Culicchia Neurological Clinic, without a physical exam. As such, there are risks and limitations of any medical opinion provided. I agree to provide copies of my medical records and any other relevant diagnostic reports or studies. I also understand as the patient requesting the remote second opinion, only I will receive a copy of the assessment and recommendation and it is my responsibility to forward the report to my treating physician(s) or other providers. I also understand that I will be provided with a second opinion only and that this request will create no physician-patient relationship with any physician at Culicchia Neurological Clinic.

(Please Print)

Patient Name_____ Date of Birth_____

Patient Mailing Address _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Please fax completed forms to Fax 504-340-6786

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Statement of Financial Responsibility- I understand that I am responsible for payment to Culicchia Neurological Clinic, LLC for this second opinion. I understand that I am ultimately responsible for all medical expenses incurred and agreed to pay all amounts.

HIPAA Regulations - I agree that Culicchia Neurological Clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for purposes of clarification of medical history.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the privacy regulations.

Patient Signature: _____

Date: _____

Please fax completed forms to Fax 504-340-6786

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Submission Checklist

Required Forms

- Patient Disclaimer (authorized signature required)
- Patient Intake Form
- Payment Authorization Form
- Medical History Questionnaire

Medical Information

- MRIs and/or CTs relevant to the diagnosis on CD; please include all imaging from the time of diagnosis including all pre-operative imaging
- Office Visit Notes relevant to the diagnosis
- Laboratory Results relevant to the diagnosis
- Pathology reports from all surgeries
- Pertinent Surgical Reports relevant to the diagnosis
- All Radiation Oncology records pertinent to the diagnosis
- Hospital Admission History and Physicals and Discharge Summaries relevant to the diagnosis
- Current Medications and Dosage Information

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Release of Liability and Acknowledgement

By requesting a remote second opinion from Culicchia Neurological Clinic, you agree to abide by the terms and conditions below.

I acknowledge and understand that this for second opinion is being provided remotely, without the benefit of a patient examination. Culicchia Neurological Clinic physicians will base this remote second opinion on materials submitted to our clinic staff and personnel.

Any opinions rendered as part of our remote second opinion service are not primary diagnoses. We recommend that you share the opinion with your neuro-oncologist and other specialists. As a remote second opinion, without the benefit of a physical exam and interview, our physicians may not be aware of patient facts, information and other relevant laboratory or imaging results that could materially affect the second opinion report. Because of this limitation, we will provide a copy of our second opinion to you, directly.

I understand the limitations and risks involved in requesting a remote second opinion.

I understand that no warranties, or guarantees will be made to you, your family or anyone else concerning your treatment, diagnosis or prognosis.

Patient signature: _____

Patient printed name:_____

Date: _____

Please fax completed forms to Fax 504-340-6786